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OVERCOMING ECONOMIC OBSTACLES TO ACHIEVING HEALTH FOR ALL AFRICANS:
HEALTH SYSTEM FINANCING IN AFRICA

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OVERCOMING ECONOMIC OBSTACLES TO ACHIEVING HEALTH FOR ALL AFRICANS:
HEALTH SYSTEM FINANCING IN AFRICA

This document reviews the existing patterns of health system financing in the Region. This is a subject of particular importance to policy makers and the general public in view of the growing economic constraints and the increasing magnitude of health problems. Far from meeting the demand for health services, the regions' health systems are also having difficulty maintaining acceptable standards of health care.

A three-pronged approach has been adopted in this document: First, how can the very limited and diminishing resources be better managed or utilized to achieve better results, wider coverage and equity? Second, given the very limited budgetary resources, what are the alternative sources of funds and other resources? Third, how are the best affordable and effective technologies selected under the circumstances? The crucial issue is the effectiveness of the system.

Following a review of the causes and effects of major problems of financing health systems of the Region such as inadequacy of funds, maldistribution of health resources, technological options in the face of rising health costs, this document proposes a number of approaches for strengthening the national capacity and alternative strategies for generating and mobilising resources. The advantages and disadvantages of each strategy are considered in the light of various experiences in the Region.

Finally, a model for health system financing is proposed based upon the identified parameters. An outline of the model is presented.

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OVERCOMING ECONOMIC OBSTACLES TO ACHIEVING HEALTH FOR ALL AFRICANS:
HEALTH SYSTEM FINANCING IN AFRICA

1. INTRODUCTION

1. Health system financing has been given increasing attention since the Alma-Ata Declaration in 1978 and the world economic crisis which began in 1983. The severe economic constraints and the apparent incapacity of governments of Member States to cope with the ever increasing demand for health care make the subject of particular concern to policy makers and the general public in the Region. Approaches to a review of health system financing are, under the circumstances, three-fold: First, how can the very limited and diminishing resources be better managed or utilized to achieve better results, wider coverage and equity? Second, given the very limited budgetary resources, what are the alternative sources of funds and other resources? Third, how does the health care system select for its clients the best affordable and effective technologies?

2. It is important to note that health system is not limited to health care alone; it includes the available preventive and curative services of the Ministry of Health and health-related activities of other ministries. Every Government is concerned about the health of its citizens and the financing of its health system; but it does not necessarily finance every aspect of the system. In this context, even the richest countries are desperately looking for ways and means of containing the costs of growing public needs and expectations.

3. Economic constraints have led to ad hoc or "unplanned" introduction, or raising, of direct charges for publicly subsidized health care without adequate prior study of the problem and the possible implications of the steps taken. Such a step should normally be part of a predetermined policy to increase cost recovery and reduce financial burden on government. Many African States have recently introduced or raised fees substantially.

4. The effect of such changes on health status, especially of the most vulnerable groups, health services utilization patterns and overall revenue and expenditure, is still not clear. This new situation calls for more in-depth study and research on health care financing policies and financing mechanisms, efficiency and equity of existing resource allocations and practices. WHO has initiated a study of the effect of the introduction, or raising, of user charges in the Region and many Member States have already

expressed interest in the proposal. By and large, any step taken must be examined realistically by:

- (a) taking into account the administrative, economic and political implications;
- (b) ensuring an improvement in the prevailing situation regarding funding, utilization of resources and equity, and
- (c) bearing in mind prevailing and changing patterns of disease and health care practices.

II PATTERNS OF HEALTH FINANCING

(a) Government budgetary allocations

5. Traditionally, governments of the Region are committed in principle through their Ministries of Health, to provide health care for all their citizens. In spite of economic constraints, attempts at direct government financing of health activities are, in varying degrees, still current. Government allocations are made for the health sector in two possible ways; from overall government tax revenue and by designating revenue from certain special taxes (such as taxes on cigarettes and alcohol) to health care. In recent years, however, many governments have had to reduce overall public expenditure in real terms, because of the economic situation and fall in national revenue.

6. Annex 1 gives a breakdown of health expenditure, percentage of GNP spent on health, and percentage of health expenditure devoted to primary health care. Annex 2 shows the percentage of government expenditure on health, education and other economic and social sectors. Many countries spend as low as 1% of GNP on health. Regarding public expenditure, only three countries spend as much as 5%. Between 1972 and 1986 only two countries increased their percentage of expenditure on health, namely, one from 5.5% to 6.9% and the other from 6.3% to 8.3%. A model country which spent as much as 10.3% of its expenditure on health in 1972, declined 7.7% in 1986. Proportion of public expenditure for health in the Region decreased from 6.1% in 1972 to 3% in 1982. It is estimated that the current figure is far less.

7. Annex 2 shows that the declining economic growth and inflation is accompanied by a fall in the percentage of expenditure on health vis-a-vis other sectors. Obviously, health has been a low priority sector in the Region, and health budgets are victims of structural adjustment policies.

The possibility of either diverting resources from other sectors or increasing the proportion to be allocated to the health sector is therefore remote under the prevailing economic situation. The system is grossly underfinanced. Consequently, it is characterised by low wages, idle assets that cannot be maintained, shortages of drugs and other essential supplies, all of which tend to make the system ineffective.

8. On the average over 50% of health allocations in the Region are made to urban hospital centres. In one country, for example, 12% of the population in urban centres use up 35% of the recurrent health budget. About 60% of Region's health budgets is spent on salaries and wages of personnel; about 30% on the purchase of drugs and supplies and only 4.8% on maintenance and running costs. The proportion spent on capital investment and development of infrastructure and new facilities is generally less than 10%.

9. Governments have been unable to give due consideration to investment to cope with the rapid growth of population, the changing innovations and technology in health science, the increasing incidence of health disasters and the need for wider coverage and effectiveness. The proportion allocated to maintenance and running costs must be adequate to minimize instances of idle or ineffective assets. In fact, maintenance and effective utilisation of existing assets should take precedence over new investments. It is not rational to buy new assets if existing ones cannot be maintained. Overstaffing accounts for the high proportion of recurrent budget on wages. Many of the staff are either insufficiently or inappropriately trained or underutilized, ineffective and frustrated because of shortages of running costs, drugs and equipment.

10. To the general public, availability of drugs determines the utilization of health services. When stocks are exhausted, visits to health centres are minimal; the staff and facilities are underutilized. But when stocks are replenished, the centres are crowded. The preferential budgetary allocation to urban centres cannot be justified from the view points of equity, economic rationale, epidemiology and effectiveness. There is therefore the need to pay more attention to health development in the rural areas, especially at the district level.

(b) Nongovernment financing

11. It is important to reiterate that budgetary allocations to the health sector is only one aspect of health system financing. Nongovernmental agencies

and individual household expenditure contribute to the financing of health and health-related activities, in varying degrees in different countries. In one country, for example, government sources accounted for 23% as against individual financing of 63% and, external donations of 12% of total and 85% of capital expenditure in 1986. In another, mission hospitals and centres provide almost 40% of the health care.

12. The following is the estimated current pattern of health system financing in the Region.

Governmental sources	45.6%
Household expenditure and direct payments	16.1%
Foreign aid	33.2%
Employers (private companies)	3.8%
Missions and charity	1.3%

The item on household expenditure does not take into account voluntary efforts and services in the construction of wells, health centres and in the running of community health committees and so forth. Also, "government sources" does not include health-related activities carried out by other ministries.

13. The following estimated pattern of individual and household expenditure in the Region. It shows percentage of funds paid to -

Private hospitals and doctors (including missionary hospitals and centres)	40.9%
Government hospitals	24.0%
Drug sellers	21.0%
Traditional healers	7.0%
Health centres	4.9%
Others	0.2%

It is estimated that about 90% of individual and household expenditure is on curative services. The trend has been towards lower governmental financing and higher individual participation. Fees or charges in respect of traditional healers may be in cash or in kind. The substantial increase in user charges for government provided health care in one country in 1985 resulted in more intensive use of private, unlicensed drug salesmen and self medication.

14. The following broad conclusions can be drawn from the patterns described in the preceding paragraphs:

- (1) Foreign aid constitute a major share of health system financing in the Region, but it is geographically selective and includes non-operational services such as training and education, research and advisory services. The relatively high salaries of international staff is included in the bill.
- (2) The low contribution of employers is due not only to insufficient efforts by employers but also reflects the small proportion of population employed in the modern sector of the regions' economies. Increase in this respect will depend largely on the expansion of the sector.
- (3) Drugs represent a major item of expenditure for governments, individuals and private hospitals. In spite of the fact that drugs are imported duty free in many countries, there is increasing disquieting evidence of dumping of faked and expired drugs.
- (4) The coverage of the rural areas, the urban centres and the poor is still inadequate in many countries. The inadequacies of health services is not compensated by the fact that a substantial proportion of people rely on traditional healers and unlicensed drug pedlars.
- (5) Inadequacy of data, statistics and preliminary studies constitutes a major constraint. Consequently, planning and budgeting are often based on guess work. There is also the problem of establishing well founded priorities under the circumstances.

III PROBLEMS OF FINANCING HEALTH SYSTEMS

(a) Inadequacy of funds

15. Funding is a major constraint. The preceding chapters have emphasised the inadequacy of funds and the low priority accorded the health sector of the Region. Less than 3% of public expenditure is currently allocated to health as compared to over 12% in the developed countries*. Budgetary allocations and foreign aid are diminishing in real terms almost as fast as health

* Source: World Bank World Development Report, 1985.

disasters and health needs are increasing. Even the maintenance of existing facilities and immediate post independence standards are not being met. The resources are just not there to cover effectively a substantial proportion of the people. To achieve the goal of Health for All by the Year 2000 would require innovations in mobilising the necessary resources.

16. Countries which have entrenched free health care in their constitutions and others which have opted for free health care for all earning less than a defined minimum wage are experiencing great hardship in keeping to their commitments. There is the additional problem of finding the necessary foreign exchange to meet health needs.

(b) Maldistribution of health resources

17. The maldistribution of resources is as serious, if not more, as the inadequacy of funds. The preceding chapter on patterns of financing shows clear bias in favour of:

- (i) urban centres vis-a-vis rural areas where the vast majority of the population live;
- (ii) the relatively rich vis-a-vis the poor who have limited access to health care and can least afford it;
- (iii) curative services as against preventive services;
- (iv) personnel salaries and wages vis-a-vis investment in health development and infrastructural facilities; and
- (v) the purchase of new and "high tech" equipment as against the maintenance of existing facilities and the provision of funds for spare parts.

In general, there is a need for a more equitable distribution of resources and carefully prepared masterplans highlighting priorities and more clearly defined objectives.

18. The view point of equity requires attention. How can the very meagre resources be stretched to cover effectively the poor masses and those who pay the taxes or provide the resources? In most countries of the Region, this is an impossible task. There is also the view that what is worth doing at all is worth doing well. One runs the risk of spreading the meagre resources too thinly across that the end result is calamitous. Both view points need to be borne in mind.

(c) Rising health costs

19. Statistics shows that the cost of health services has risen much faster than the cost of living in both the developed and developing countries. Rising health costs constitute a major problem in health system financing in the Region, considering:

- (i) the high rate of inflation;
- (ii) the deteriorating national earnings and income per capita, in real terms;
- (iii) the fact that most of the drugs and equipment have to be imported and paid for in foreign exchange; and
- (iv) frequent devaluation of currencies in many of the Member States.
- (v) high local demand in view of high rate of population growth and increasing health hazards.

For example, in one country (as in many other countries) 1000 tablets of imported chloroquine rose from Sh.170 in 1986 to Sh.1300 in 1988. This dramatic rise reflects increases in both dollar and shilling terms.

(d) Management

20. For a region with meagre resources, good management is of paramount importance. It determines effectiveness. There are innumerable instances of overstaffing, misuse of funds, drugs and instruments, and underutilization of resources in many health systems of the Region. Basic management issues such as inadequate records, poor stock and stores control and poor planning may result in poor allocation of resources and wastage. Clear definition of functions and responsibilities; cost consciousness and public accountability at all levels and the establishment of an adequate monitoring and evaluation systems are some of the essential pre-requisites for effective utilisation of the diminishing resources available to the health sector.

21. Perhaps more important is the need for more effective coordination between national health care institutions. It has not always been easy to coordinate health activities within the public sector not to mention coordination in both public and private sectors. In the public

sector, for example, there is need to coordinate the activities within the health sector, between the health ministry and the other ministries and promote a dialogue between the providers and users of health services. Problems of coordination become more complex when there are different sources of finance. With the growing tendency towards decentralisation and, in some countries, greater private sector participation, the need for coordination is becoming more pronounced. The guiding principle is that efforts at every level should be in accord with the national health strategy. The same is true of external technical assistance that should, at its best, complement the national health system.

IV. PROPOSALS FOR REMEDY

(a) Strengthening national capacity to finance the health sector

(i) Public sector budget

22. First and foremost, the low priority accorded the health sector of the region needs to be reviewed by the various governments. At the 34th World Health Assembly in 1987, 5% of GNP was set as the target for countries aiming at Health for All by the Year 2000. Adherence to this target will enhance the leadership role of government, encourage further private sector participation, stimulate involvement of communities, and foster a self-reliant and self-sustaining health system.

23. Apart from general tax revenues, the national capacity for government spending in the health sector can be realistically enhanced by:

- (i) earmaking special taxes on items such as entertainment, alcohol and cigarettes for health care of vulnerable groups in rural and urban areas;
- (ii) ensure that funds from other sectors (especially agriculture, food and nutrition, public works, housing, water supplies, education, public information) effectively promote health and reduce disease burden;
- (iii) charging fees for services rendered under a cost-recovery scheme and reinvest these in the health system.

Each of these approaches requires careful study of its possible implications before any decision is taken. The competing demands are always so strong that

marginal increases in government allocation, if any, are likely to meet with resistance. In a number of countries, a proportion of fees/taxes collected at the local level is retained for local health and other services. However, so much depends on the overall national priorities and the capacity of the health sector to convince planners that health is a productive activity - it produces healthy people (work force) and keeps them in good health.

(2) Investment policy

24. It is noted in paragraph 8 that less than 10% of government budgetary allocation is earmarked for capital investment and development of infrastructure and new facilities. For a Region with the fastest population growth in the world (3.2% annual growth) and low health status, inadequate investment constitutes yet another major problem. Because of the high rate of growth, the population is young and this enlarges the size of the vulnerable group.

25. To maintain existing standards of living (and health care), economists work on the premise that a nation needs at least 4% of the national income as investments to meet the requirements of one percent of annual population growth. For a nation with 3% population growth, this amounts to 12%. Although this would be unrealistic at this time, it is proposed that selective investments in health development should be accorded top priority. Investments are crucial for public security and will enhance the system's capacity:

- (i) to cope with the population growth, especially for mothers and babies;
- (ii) to attain significant improvements in standards and wider coverage of disease control services; and
- (iii) to fill significant gaps in the health infrastructure, especially at the local level.

(3) Selection of affordable technologies

26. Technology can be defined as "an association of methods, techniques and equipment together with the people using them". Technologies may be traditional or modern (i.e. recently discovered), in either case, local or imported. Obviously, traditional locally available technologies are more likely affordable than modern or imported. Policy makers and consumers would, however, be concerned with effectiveness, since the latter would in the long run be economical.

27. Use of technologies would depend upon the levels of the health care system; most highly qualified and specialized usually find themselves (justifiably or not) at the apex of the system; the less qualified who are most numerous occupy the base of the pyramid, close to where people live and work.

28. Decentralization is an inevitable feature of such a system; the principle being that no one undertakes tasks which can be performed as well by less qualified, less costly personnel. It is important to emphasize that the simplest and most affordable technologies can and do resolve the most prevalent health problems; more complex and more expensive technologies are reserved for more difficult but less common problems. It is vital that each country, or a subregion including a number of relatively small countries, be self sufficient technologically; and that access to health care be equitably distributed.

29. This does not mean that national medical centres in the capital cities or those in provincial capitals should not be fully equipped. But such "high tech." should be accessible to those unfortunate few who need it wherever they live. A judicious selection and distribution of affordable technologies for primary, secondary and tertiary care would result in effective health care at minimum cost. Operational Research and continuing education are crucial for technology selection and adaptation to local circumstances.

(c) User charges

30. In view of the constraints on financing the health system, a number of Member States are known to have introduced or raised fees for health services in recent years. They include the Republic of Benin, Ghana, Niger, Kwanda, Madagascar, Mozambique, Botswana, Nigeria and Liberia. A few others are considering doing so. However, as pointed out in paragraph 4, very little is yet known about the effect of such measures on health status, the resulting change in health services utilization patterns and; most importantly, the effect on the vulnerable groups. There is also need to assess in each case the net revenue and the possible changes in the quality and coverage of services provided. These are crucial issues for health policy makers. WHO is taking necessary action to undertake a comprehensive study on the subject.

31. Nevertheless, user charges have several potential advantages apart from reducing the burden on government: (i) income generated can be utilised to develop other priority health services; (ii) services are more likely to

improve in quality if fees are retained at the community/district where they are collected; (iii) the introduction of fees will make users take more rational decisions on the use of health services. This will reduce unnecessary use of services and give health workers more time to improve the quality of care.

32. The possible disadvantages are equally striking: (i) the very people who are likely to benefit from the provision of health care service may not be in a position to afford the charges, others may use the service less because of the cost; (ii) users are more interested in paying for curative and "high-tech" services and the introduction of user charges may therefore tend to ignore preventive services and appropriate technologies such as immunization and oral rehydration; (iii) the overall increase in revenue may be so little after deducting administrative costs. Empirical studies are therefore necessary to determine the possible effects of user charges and the extent of fees to be charged.

33. In July 1985 fees were substantially raised in one country for the first time in over a decade. Each health unit retains a percentage of the fees collected and the balance is paid to the Treasury in accordance with the governments cost recovery system. Such fees now constitute 20% of the government revenue from non-hospital health facilities.

34. The immediate consequence of the increase in one district was an instant drop of over 50% in attendance at most health centres. Three years after, utilization of health centres rose to 30% of the pre July 1985 level. At the urban health units, utilization rate was restored to previous level within 18 months. But the level of utilization in the health units remained substantially low. Another outcome of the increase is that the rural population appears to be relying more on unlicensed drug salesmen, self medication, traditional healers and, at best, missionary hospitals where increases have been more gradual. The overall effect of the increase on health status in the rural sector is yet to be determined.

(d) Revolving Drug Fund

35. A variety of organisations ranging from communities, village health committees, welfare groups, cooperatives and local government authorities have been organised as the basis for running Revolving Drug Fund. Such a Fund ensures the reliability of supplies at a reasonable price and the maintenance of a stock of essential drugs. The Fund's principle is that expenses should

equal receipts from sales and all funds are recovered after making reasonable provision for losses and leakages. This scheme has been tried with varying success in some Member States.

36. In one country where the concept of user fees was introduced since 1979, there is a nation wide village health service system covering 298 villages. A fund, under the management of the Village Development Committee, is made up of proceeds from the sale of prescribed drugs. Drugs are purchased from the Regional Medical Stores. The government bears the costs of supervision and provides small annual grants to each Village Development Committee.

37. Another country which had free medical services until 1985, established the National Drug Service (NDS); a Revolving Fund that operates on the basis of "no money, no drugs". The government, however, earmarks some money to the health centres in respect of the vulnerable group. The NDS had a surplus of 9% in 1986 and 6% in 1987. Above all, utilization of health facilities increased by 19% in 1986 and 36% in 1987. The morale of staff has also improved since NDS began with stock provided by WHO, UNICEF and USAID. The reasons for the resounding success include: (i) constant availability of drugs; (ii) effective publicity; (iii) lower prices and (iv) favourable attitude of acceptance.

38. Similar success has been recorded yet in another country where the scheme was introduced in six districts and the western area in mid 1986. Here, success has been mainly due to its effective supply distribution logistics system, good planning and management and the introduction of simple but effective record keeping systems.

(e) The Bamako Initiative

39. The Bamako Initiative was formally introduced in September 1987 by African Ministers of Health of the Region. The main objective is universal accessibility to primary health care with emphasis on women and children by strengthening local financing and management. It is designed to encourage maximum community involvement through initial provision of basic essential drugs and supplies, the proceeds from which can be utilized to build up a system of user-financing and cost recovery and a revolving fund. This would be utilized in financing other components of the primary health care (especially for mothers and children), and to promote management capability at the district level.

40. In practice, the international community, through WHO and UNICEF, would provide the first consignment of drugs free of charge and the proceeds of the sale are used to restock the system, and create a revolving fund. Due consideration is given to the vulnerable groups. There are also special arrangements for communities that do not succeed with the initial stock of supplies: although the project aims at making the community and the nation self-reliant, the international community has an important role to play by making foreign exchange available for the importation of essential drugs and providing necessary encouragement and support.

41. One country of the Region provides spectacular success stories of the Bamako Initiative type of projects with WHO and UNICEF support. Over 40% of the country's population is now covered under the system. Thirty-five non-governmental organisations bilateral and other multilateral organisations and missionary hospitals are actively implementing the Bamako Initiative approach. Panou, a community of 20 000, has been the show piece. Several missions have been undertaken by representatives of other communities or other countries to study the system. The approach is quite flexible and can be adapted to fit various communities. In October 1988, the Government enacted a law on Essential Drugs which will foster further Bamako Initiative in the country.

(f) Health insurance mechanisms

42. There are various insurance schemes to assist individuals to finance health services. Each of them involves the collection of funds or premium on a regular basis from the insurer in respect of the potential users (the insured), some are compulsory, others are voluntary. The money collected forms a pool which can be drawn upon in case of illness. A number of employers make such arrangements in respect of their workers. So far such schemes cover a minute fraction of the population. In one country, for example, health insurance covers only 22 000 employees in the private sector in 1982, out of a total population of 7.5 million.

43. Insurance contributions are easier to collect than tax. Contributors are also more willing to pay because of the evident benefits. Contributions vary according to people's income. This is an advantage from the equity point of view. There is considerable scope for the development of voluntary insurance schemes in rural communities of the Region.

V. A FRAMEWORK FOR HEALTH SYSTEM FINANCING

44. Annex 3 provides guidelines for the preparation of a three dimensional model for national health system financing. The proposed model takes account of the existing patterns and problems of financing health systems and the implications of alternative strategies for improving health system financing and effectiveness. The three dimensions adopted are (1) the major sources of funds, (2) the major items of expenditure and (3) the levels of health care activities - the central, intermediate and peripheral levels respectively.

VI. CONCLUSION AND RECOMMENDATIONS

45. Considering the prevailing economic constraints on governments, it is essential that alternative strategies for financing the health systems in the region be adopted after careful study of their implications by health authorities.

First, it is important that utilization of existing resources is cost effective. This involves better management and coordination and the development of efficient data collection system and statistics necessary for planning purposes and decision making.

Second, to ensure sufficiency of funds, alternative strategies must be carefully studied to ensure stable flow of resources, equity and accessibility of health care to all, particularly the vulnerable groups. Unexpected shortages of funds and drugs and non payment of salaries can destabilise the system. Care must be taken to see that the burden of health financing is fairly distributed and does not fall too heavily on any particular group. Third, every strategy adopted should enhance utilisation of services, wider coverage of the population with primary health care and accelerate the attainment of Health for All by the Year 2000.

46. Substantial decentralisation and focus on the district level will facilitate wider coverage, efficiency and self-reliance. It is by far, the most effective way of mobilising resources in support of the health system. As the communities become more self-reliant, the public sector will also be expected to play greater leadership role by enhancing its efforts in areas of investments and the provision of the necessary infrastructural facilities, training and research, management and particularly coordination.

47. Pricing policy for drugs and determination of fees for services are absolutely critical. They must be such that they do not encourage over use or

misuse or underutilization of health facilities. Exemption policies are also difficult to administer and should therefore be limited. The larger the number of exemptions, the higher is the burden on the others under a full cost recovery scheme. Here consultation with the community or users is necessary to identify those to be exempted, to solicit their cooperation in collecting and safeguarding funds and to determine affordable rates or fees.

48. To attain self-reliance, local production of drugs and other health facilities need to be encouraged, especially in areas where the raw materials are available locally. This will entail intersectoral cooperation between the health and industry sectors. In some countries, the Department of Industry, in collaboration with the Department of Health, are engaged in the production of drugs using local medicinal plants.

49. Finally, the proposed Special Health Fund for Africa is yet another essential financing strategy that deserves attention.

Table 1
Health Expenditure

Country and area	GNP per head		Percentage of GNP spent on health		Percentage of health expenditure devoted to PHC	
	(US \$)	Year	%	Year	%	Year
Algeria	2 320	1983				
Angola	470	1982				
Benin	290	1983	1.0	1983		
Botswana	6 480	1984	3.4	1984	48.0	1985
Burkina Faso	240	1982	9	1981		
Burundi	180	1984			30.0	1984
Cameroon	880	1982				
Cape Verde	317	1985	1.0	1981		
Central African Republic	280	1983	2.1	1985		
Chad	80	1984				
Comoros	300	1984				
Congo	1 230	1983				
Côte d'Ivoire	950	1982	1.4	1980		
Equatorial Guinea	180	1982				
Ethiopia	120	1983	1.8	1981	27.2	1984
Gabon	3 950	1983	2.7	1983	65.0	1983
Gambia	250	1983			7.0	1983
Ghana	310	1983				
Guinea	300	1984	1.5	1984		
Guinea Bissau	160	1983	3.7	1984	30.0	1984
Kenya	200	1983	2.1	1983		
Lesotho	623	1984	1.4	1984	43.0	1983
Liberia	520	1984	3.0	1983	23.0	1983
Madagascar	210	1983			61.0	1984
Malawi	262	1984	3.0	1984	46.0	1984
Mali	120	1983	1.0	1983	24.6	1984
Mauritania	185	1983	7.6	1984	59.9	1984
Mauritius	923	1983	3.0	1983		
Mélanésie	270	1981	2.6	1983	40.0	1982
Moldavia	1 410	1980				
Niger	240	1983			53.2	1984
Nigeria	770	1983				
Reunion	3 830	1980				
Rwanda	236	1981				
Saint Helena						
Sao Tome and Principe	264	1983	6.8	1983	45.0	1982
Senegal	440	1983				
Seychelles	2 224	1985	3.8	1984	17.0	1984
Sierra Leone	320	1984	6.7	1984	15.0	1984
Swaziland	940	1982			11.7	1984
Tanzania	270	1982				
Togo	264	1984	4.5	1982	50.0	1982
Uganda	230	1984				
Zaire	170	1983	2.5	1985		
Zambia	580	1983				
Zimbabwe	730	1983	2.6	1982	37.0	1982

Source: WHO/AFRO

	Percentage of total expenditure							
	Defence		Education		Health		Housing amenities social security welfare	
	1972	1986	1972	1986	1972	1986	1972	
Ethiopia	14.3	-	14.4	-	5.7	-	4.4	
Burkina Faso	11.5	19.2	20.6	17.7	8.2	6.6	8.3	
Botswana	0.0	6.4	10.1	17.7	6.1	5.0	21.5	
Burundi	10.3	-	23.4	-	6.0	-	2.7	
Cameroon	-	8.8	-	14.4	-	5.1	-	
Chad	24.6	-	14.8	-	4.4	-	1.7	
Congo	-	-	-	-	-	-	-	
Côte d'Ivoire	-	3.9	-	20.5	-	4.0	-	
Gabon	-	-	-	-	-	-	-	
Ghana	7.9	6.5	20.1	23.9	6.3	8.3	4.1	
Kenya	6.0	8.7	21.9	19.7	7.9	6.4	3.9	
Lesotho	0.0	9.6	22.4	15.5	7.3	6.9	6.3	
Liberia	-	7.7	-	14.2	-	5.7	-	
Madagascar	3.6	-	9.1	-	4.2	-	9.0	
Mali	-	8.1	-	9.0	-	1.7	-	
Malawi	3.1	6.0	15.8	11.0	5.5	6.9	5.8	
Nigeria	40.2	-	4.5	-	3.6	-	0.8	
Mauritius	0.8	0.8	13.5	13.4	10.3	7.7	3.1	
Uganda	25.6	-	22.2	-	5.7	-	2.6	
Senegal	-	-	-	-	-	-	-	
Papua-New Guinea	-	4.5	-	17.0	-	9.6	-	
Samalia	23.3	-	5.5	-	7.2	-	1.9	
Sierra Leone	-	3.4	-	12.8	-	5.8	-	
Sudan	24.1	-	9.3	-	5.4	-	1.4	
Togo	-	6.9	-	11.7	-	3.6	-	
Tanzania	11.9	13.8	17.3	7.2	7.2	4.9	2.1	
Uganda	23.1	26.3	15.3	15.0	5.3	2.4	2.3	
Zaire	11.1	-	15.2	-	2.3	-	2.0	
Zimbabwe	-	15.2	-	20.9	-	6.2	-	
Zambia	0.0	-	19.0	16.0	7.4	7.2	1.3	

Source: The courier No.11

Expenditure

	Economic services		Other		Total expenditure (% of GDP)		Overall surplus/deficit (% of GDP)	
and	1972	1986	1972	1986	1972	1986	1972	1986
1986								
-	22.9	-	38.3	-	13.7	-	-1.4	-
15.5	13.9	37.6	34.7	11.1	13.2	0.3	1.6	
7.3	27.9	29.7	34.3	34.0	33.6	49.4	-23.8	31.8
-	33.9	-	23.8	-	19.9	-	0.0	-
11.4	-	33.8	-	26.6	-	22.4	-	0.8
-	21.8	-	32.7	-	14.9	-	-2.7	-
-	-	-	-	-	-	-	-2.7	-
1.8	-	31.5	-	38.3	-	31.2	-	-3.1
-	-	-	-	-	40.1	41.0	-12.9	0.1
7.3	15.1	15.7	46.6	38.3	19.5	14.0	-5.8	0.1
0.5	30.1	27.6	30.2	37.0	21.0	27.8	-3.9	-6.7
1.5	21.4	25.5	42.7	41.0	14.5	24.2	3.5	-2.6
1.8	-	34.5	-	36.2	-	27.1	-	-9.0
-	40.5	-	33.7	-	20.8	-	-2.5	-
6.2	-	7.7	-	67.3	-	34.0	-	-9.6
1.9	33.1	30.5	36.8	43.7	22.1	31.5	-6.2	-8.4
-	19.6	-	31.4	-	10.2	-	-0.9	-
1.6	13.9	12.4	58.3	64.1	16.3	24.9	-1.2	-3.5
-	22.0	-	21.9	-	12.5	-	-2.7	-
-	-	-	-	-	18.8	-	-2.8	-
2.0	-	18.6	-	48.3	-	34.8	-	-2.6
-	21.6	-	40.5	-	13.5	-	0.6	-
2.0	-	15.4	-	60.4	-	13.6	-	-8.9
-	15.8	-	44.1	-	19.7	-	-0.8	-
9.2	-	23.5	-	45.2	-	42.3	-	-5.1
1.4	39.0	24.0	22.6	48.6	19.9	23.9	-5.1	-
0.8	12.4	14.8	30.6	40.7	21.8	9.4	-8.1	-2.8
-	13.3	-	56.1	-	-	-3.8	-	-
4.7	-	10.0	-	27.0	-	35.2	-	-7.0
2.6	26.7	16.1	45.7	58.1	34.0	38.2	13.8	16.3

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HEALTH SYSTEM FINANCING: GUIDELINES FOR A MODEL

1. Objective

Health for All by the Year 2000.

2. Pre-requisites

1. Total national commitment towards attaining above objective based on high level of political will and determination.
2. National development plan, indicating adequate priority for health sector and assurance of adequate share of GNP.
3. National Health Masterplan
 - (a) based on, and consistent with, the National Development Plan
 - (b) must be politically, financially and administratively feasible
 - (c) must indicate national health policies and plan of action;
 - (d) must include necessary financial projections on recurrent and capital budgets and show relationship between them;
 - (e) must be based on careful and detailed study of:
 - (i) existing health structure and status, facilities, health services utilization patterns and rates of coverage;
 - (ii) overall health needs and population growth;
 - (iii) the vulnerable groups.
 - (f) must spell out the role of all concerned.

3. Criteria for model

1. Equity, with particular attention given to:
 - (a) sharing the burden of the system fairly according to one's capability;
 - (b) the vulnerable group in society, particularly the very poor, mothers and children and the neglected rural areas.
2. Adequate funding, consistent with a reliable revenue plan and providing carefully selected and tested incentives.
3. Effectiveness.

4. Intersectoral linkages and cooperation, particularly with:
 - (a) other ministries responsible for health-related activities, such as water supply, housing, education and agriculture;
 - (b) foreign technical assistance support.

4. Indicators for determining national capacity and attitudes

1. Gross National Product (per capita) is a positive indicator of national (particularly government) capacity.
2. Income per capita and distribution of income patterns are indicators of the capacity of individuals, communities or groups.
3. Low cost of living is also a positive indicator of individuals capacity.
4. Percentage of public health expenditure vis-a-vis other sectors is an indicator of decision makers' assessment of the importance of health in national socioeconomic development.
5. Proportion of private expenditure vis-a-vis public expenditure is an indicator of effort made by the private sector within the system. Conversely, it may also be a reflection of the inadequacies of state sponsored health institutions.
6. Revenue from fees for health services and other cost recovery schemes vis-a-vis the level of utilization of health services reveal the extent of receptiveness to increases (or introduction) of fees.

5. Three dimensional model

1. Sources of funds

- (i) Government budgetary allocation;
- (ii) Individual sources, including payment of fees for services, purchase of drugs, etc.;
- (iii) Community efforts, including other private sector groups such as companies;
- (iv) Local nongovernmental organizations such as missionary hospitals;
- (v) Foreign technical assistance, including unilateral, bilateral and multilateral sources.

2. Expenditure items

- (i) Health personnel salaries and wages;
- (ii) Drugs and supplies;
- (iii) Other running costs;
- (iv) Maintenance;
- (v) Capital investment;
- (vi) Training and research;

- (vii) Subsidy for vulnerable groups;
- (viii) Special fund for emergencies.

3. Resource allocation

- (i) Central;
- (ii) Intermediate;
- (iii) Periphery, consisting of the vast majority of the population.

6. Guidelines for filling the table

1. Expenditure

The masterplan and national priorities will determine the weight to be placed on each expenditure item, after considering existing health funding pattern (HFP) and the desired HFP, taking an optimal number of correlated factors into account.

2. The sources of fund

The three sources of national revenue will be based on GNP, income per capita, distribution of income and empirical studies on the implications of additional fees or charges on each group. The amount of technical cooperation can be pre-determined in accordance with commitment to assist on the basis of the masterplan. It is assumed that foreign support will foster self-reliance and complement national effort.

3. Allocations to central, intermediate and periphery levels

This will depend on population distribution, distribution of income and the neglected areas.

8. Limitation of model

This model does not reflect:

- (a) expenditure for curative as distinct from preventive and promotion of health activities - however, the distinction must not be overlooked in determining government budgetary allocations and foreign technical cooperation activities;
- (b) payments in kind and material and voluntary support;
- (c) expenditure on health-related sectors.

FRAMEWORK FOR HEALTH SYSTEM FINANCING MODEL

EXPENDITURE	LEVEL	S O U R C E					TOTAL
		Govern- ment	Indivi- dual	Commu- nity	Local NGOs	Foreign Aid	
Salaries	Central						
	Interm.						
	Periph.						
Drugs & Supplies	Central						
	Interm.						
	Periph.						
Maintenance	Central						
	Interm.						
	Periph.						
Other running costs	Central						
	Interm.						
	Periph.						
Capital investment and new infrast.	Central						
	Interm.						
	Periph.						
Training and research	Central						
	Interm.						
	Periph.						
Subsidy for vulnerable groups	Central						
	Interm.						
	Periph.						
Emergencies	Central						
	Interm.						
	Periph.						
TOTAL	Central						
	Interm.						
	Periph.						

	Total						